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THE A.M.A. DOWN UNDER

ONE of the noteworthy phenomena in the socio-political history of the past century has been the emergence to independent status of heretofore colonial nations. Sooner or later this pattern of evolution to political nationhood has been followed, in most of these countries, by the banding together of their doctors in the organization of independent national medical associations. The most recent blessed event in the family of organized medicine was the birth of the Australian Medical Association. This lusty infant, which first saw the light of day on January 1 of this year, celebrated the occasion with appropriate pomp and ceremony at its Inaugural Meeting which was held in Adelaide on May 19, as described in detail by Dr. Stanley Gilder in a recent issue of this Journal.[1] In commemoration of this event the new A.M.A. issued a special edition of *The Medical Journal of Australia* (Vol. 1: No. 20, May 19, 1962) which contains in some 47 pages of text an admirable account of the saga of organized medicine in Australia, Britain, the Commonwealth nations and the United States of America.

In some respects the early stages of gestation of the Australian Medical Association were similar to those of the Canadian Medical Association; both developed by a process of fusion of existing regional medical societies and in both countries these pioneer professional groups experienced their share of trials and tribulations, many of them succumbing to the corrosive influence of internecine strife. Nevertheless, it was in no small part due to the heritage created by those which survived that strong foundations were laid, on which the larger and sturdier edifices of the present-day national medical associations in these two countries were erected.

Among the Australian colonies the first medical organization strong enough to survive was the Medical Society of Victoria, which was established successfully in 1852. In the late 1870's the influence of the British Medical Association, itself created in 1832, began to extend to the Australian colonies, and in 1879-1880, B.M.A. Branches were set up in the states of South Australia, New South Wales and Victoria, in that order of precedence. Queensland, in 1894, Western Australia, in 1899, and finally Tasmania, in 1911, followed suit. As might be expected, a certain amount of friction and rivalry existed between the new B.M.A. Branches and such previously established independent state medical societies as were in existence at the time, but eventually these splinter groups amalgamated and by the early part of the twentieth century each of the states became the base of a flourishing Branch of the British Medical Association.

Federation of the States of the Commonwealth was accomplished in 1901, and like the Confederation of the Canadian provinces 34 years earlier, this political event provided a stimulus for the creation of a national medical body to represent the state societies in various matters at federal level. This organization, the Federal Committee of the British Medical Association in Australia, took form more gradually than did the Canadian Medical Association, for it was not created until 1912, when it assumed its prime function as an advisory body to the Branches in medical or political matters of a national character. One of the Federal Committee's most important acts was the formation of the Australasian Medical Publishing Company which was registered in 1913 and issued the first number of *The Medical Journal of Australia* on July 4, 1914. This publication of a national medical journal has proved to be a most successful joint B.M.A. Branch effort and has contributed materially towards the unification of the profession in Australia.

Soon after its formation the Federal Committee was confronted with another important policy decision regarding the autonomy of the B.M.A. Branches in Australia and their authority to deal with matters of local concern. This decision was precipitated by the imminence of government legislation designed to introduce a program of national health insurance and nationalization of hospitals. After a number of years of earnest negotiation with the B.M.A. in London, the long awaited autonomy of the Australian Branches was finally granted in 1923.

The achievements of the Federal Committee during its 21 years of existence were many and varied. It established a sound relationship between the medical profession and the Commonwealth Government and it played an active role in the formulation of a federal code of medical ethics, in creating a uniform system of registration of medical practitioners, in the promotion of medical research, in the advancement of military medicine, in the guidance of projected national insurance bills of the Commonwealth Government, and finally, in

the drafting of a constitution for its successor, the Federal Council of the British Medical Association in Australia.

Although the parent body of the B.M.A. had granted its Australian Branches their autonomy in 1923, and with it, permission to form a regional council, it was not until 10 years later, in 1933, that the Federal Council of the B.M.A. in Australia became established after four years of negotiation with the State Branches to reach agreement on the form of the Council's constitution.

With the expansion of the National Health Service that has taken place over the past 30 years in Australia, a considerable portion of the Federal Council's activities have been concerned with negotiations with the Commonwealth Health Department. Particularly noteworthy in this respect was its successful action during the late 1940's in combating the Labour Government's attempt to introduce legislation to nationalize medicine, and its co-operation with and support of a subsequent Minister of Health, the late Sir Earle Page, who introduced a national health program based on government-subsidized, voluntary health insurance.

Functioning with the full support of the B.M.A. Branches, whose membership included 80 to 90% of all practitioners in the country, the Federal Council came to be generally recognized as the representative body of the entire medical profession in Australia. Its last great task, which culminated in its own dissolution, was the organization of the Australian Medical Association at the beginning of this year.

Before 1950 some consideration had been given to the desirability of establishing an independent national medical association in Australia but no definite action in this direction was taken until 1959. In September of that year the Federal Council passed a resolution expressing the opinion that ". . . the time is now opportune to proceed with the formation of an Australian Medical Association, independent of but affiliated with the British Medical Association". Events thereafter moved with remarkable rapidity. At a memorable convention of representatives of the Australian Branches of the B.M.A. and some 29 other existing Australian and Australasian medical organizations, held in Sydney on November 26 and 27, 1960, the Federal Council was authorized to proceed with this project. The Australian Medical Association was duly registered at Canberra on October 25, 1961, and commenced to function on January 1, 1962, with the six former State B.M.A. Branches becoming Branches of the new Association.[2]

Needless to say, our colleagues down-under enjoy the well-deserved admiration, respect and best wishes of the doctors of Canada for their continued success in this new era upon which organized medicine in Australia has so recently embarked.

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1. GILDER, S. S. B.: *Canad. Med. Ass. J.*, 87: 151, 1962.
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POLYPS OF THE COLON AND RECTUM

CARCINOMA of the colon and rectum is the most common type of visceral cancer and the most common type of malignant tumour other than cancer of the skin. It has been estimated that in the United States, in 1961, there were 70,000 new cases of cancer of the colon and rectum, and that, in that year, deaths from this cause would number 39,000.

In many ways the prognosis for carcinoma of the colon and rectum is significantly better now than it was 10 years ago. At that time, the five-year survival of a group of patients with cancer of the colon and rectum treated at the Massachusetts General Hospital was 26%; in a recent survey at the same institution covering the period January 1, 1949 to December 31, 1960, the five-year survival was calculated as 38%. In the earlier survey, the five-year survival of patients who survived resections carried out with a view to cure was 45%, and in the later study it was 58%. Now, however, it seems possible that another plateau has been reached from which any further significant improvement will probably be dependent upon radical changes in diagnostic and/or therapeutic procedures. In recent years advances in surgical techniques have permitted much more extensive operation. Despite the accessibility of the majority of malignant tumours to clinical examination, however, not over 10% of them are diagnosed in asymptomatic patients. Thus, it is possible that improved techniques to increase the number of asymptomatic tumours that are diagnosed would result in a further improvement in the prognosis.[1]

Clinically, precancerous conditions of the colon and rectum, with the exception of ulcerative colitis, present essentially as polypoid lesions of the intestinal mucosa.[2] However, not all intestinal polyps are precancerous. Only the adenoma, papillary adenoma and villous papilloma, all three of which are different anatomical modifications of an essentially similar neoplastic process, are premalignant. Although these lesions are premalignant, this does not imply that they invariably become malignant, nor does it mean that carcinoma of the large intestine invariably arises in such a benign tumour.

In an attempt to determine more precisely the relationship of carcinoma of the colon to adenomatous polyps and villous adenomas, and the specific danger to the patient from an adenoma containing an area of carcinoma, Enterline *et al.*[3] carried out a study of all carcinomas of the colon, villous adenomas, and adenomatous polyps encountered during the period 1945 to 1955, and all of the adenomatous polyps containing areas of carcinoma that were encountered during the period 1942 to 1958, at the Hospital of the University of Pennsylvania. Among approximately 1700 polyps removed surgically, there were 61 adenomatous polyps containing areas of carcinoma and 81 villous